AMENDED IN ASSEMBLY MARCH 25, 2003

CALIFORNIA LEGISLATURE—2003–04 REGULAR SESSION

ASSEMBLY BILL No. 432

Introduced by Assembly Member Kehoe

February 14, 2003

An act to ~~amend Section 1371.37 of~~ *add Section 1371.40 to* the Health and Safety Code, *and to add Section 10123.146 to the Insurance Code,* relating to health care ~~service plans~~ *coverage*.

LEGISLATIVE COUNSEL'S DIGEST

AB 432, as amended, Kehoe. ~~Health care service plans: unfair payment patterns~~ *Coordination of benefits: secondary payor requirements.*

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the regulation and licensure of health care service plans by the Department of Managed Health Care ~~and includes provisions pertaining to the payment of provider claims by a health care service plan and to the resolution of claims disputes. Existing law prohibits a health care service plan from engaging in an unfair payment pattern, as defined, in its reimbursement of a provider and authorizes the director to impose sanctions for a violation of this prohibition~~. *Existing law also provides for the regulation of health insurers by the Department of Insurance. Under existing law, a health care service plan and a health insurer are required to reimburse provider claims within a specified timeframe.* The willful violation of the provisions governing health care service plans is a crime.

This bill would ~~include as an unfair payment pattern a health care service plan's failure when acting as a secondary or supplemental plan~~

~~to provide full reimbursement, as defined, to a health care provider~~ *specify the requirements for payment of a provider claim by a health care service plan or a health insurance policy when it is a secondary payor under a coordination of benefits provision*.

Because ~~this~~ *the* bill would specify an additional ~~form of prohibited conduct under the Knox-Keene Health Service Plan Act of 1975~~ *requirement for the operation of a health care service plan*, the willful violation of which ~~is~~ *would be* a crime, ~~the bill~~ *it* would ~~create a new crime and thus~~ impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

~~SECTION 1. Section 1371.37 of the Health and Safety Code~~

SECTION 1. Section 1371.40 is added to the Health and Safety Code, to read:

1371.40. (a) Notwithstanding its fee schedule, a health care service plan that is the secondary payor under a coordination of benefits provision shall pay the entire balance of the claim, including all copayments, that are not paid by the primary payor under the coordination of benefits provision.

(b) If the health care service plan that is the primary payor under a coordination of benefits provision pays the claim of a provider on a capitated or prepaid basis, the health care service plan that is the secondary payor shall reimburse the provider for the copayment in the amount established by the primary payor for capitated services.

(c) A health care service plan that is the secondary payor under a coordination of benefits provision shall in no event be liable for an amount that exceeds the amount it would have been required to pay on the claim if it were the primary payor.

(d) This section shall not affect a provider's right to be reimbursed usual, customary, and reasonable charges when the provider does not have a contract with the health care service plan.

SEC. 2. Section 10123.146 is added to the Insurance Code, to read:

10123.146. (a) Notwithstanding its fee schedule, an individual or group health insurance policy that is the secondary payor under a coordination of benefits provision shall pay the entire balance of the claim, including all copayments and other amounts that the insured is required to pay, that is not paid by the primary payor under the coordination of benefits provision.

(b) If the health insurance policy or the health care service plan that is the primary payor under a coordination of benefits provision pays the claim of a provider on a capitated or prepaid basis, the health insurance policy that is the secondary payor shall reimburse the provider for the copayment in the amount established by the primary payor for capitated services.

(c) A health insurance policy that is the secondary payor under a coordination of benefits provision shall in no event be liable for an amount that exceeds the amount it would have been required to pay on the claim if it were the primary payor.

(d) This section shall not affect a provider's right to be reimbursed usual, customary, and reasonable charges when the provider does not have a contract with the health insurer.

~~is amended to read:~~

~~1371.37. (a) A health care service plan is prohibited from engaging in an unfair payment pattern, as defined in this section.~~

~~(b) Consistent with subdivision (a) of Section 1371.39, the director may investigate a health care service plan to determine whether it has engaged in an unfair payment pattern.~~

~~(c) An "unfair payment pattern," as used in this section, means any of the following:~~

~~(1) Engaging in a demonstrable and unjust pattern, as defined by the department, of reviewing or processing complete and accurate claims that results in payment delays.~~

~~(2) Engaging in a demonstrable and unjust pattern, as defined by the department, of reducing the amount of payment or denying complete and accurate claims.~~

~~(3) Failing on a repeated basis to pay the uncontested portions of a claim within the timeframes specified in Section 1371, 1371.1, or 1371.35.~~

~~(4) Failing on a repeated basis to automatically include the interest due on claims pursuant to Section 1371.~~

~~(5) Failing to provide full reimbursement to a health care provider when acting as or in the position of a secondary or supplemental health care service plan.~~

~~For purposes of this paragraph, "full reimbursement" includes payment for copayments and deductibles, and means either:~~

~~(A) The difference between the amount paid by the primary health care service plan and the allowed amount under its fee schedule, but not to exceed the secondary or supplemental plan's fee schedule.~~

~~(B) In the event that the primary plan pays the health care provider on a capitated or prepaid basis, reimbursement to the provider of the normal amount allowed under the fee schedule of the secondary or supplemental plan.~~

~~(d) (1) Upon a final determination by the director that a health care service plan has engaged in an unfair payment pattern, the director may:~~

~~(A) Impose monetary penalties as permitted under this chapter.~~

~~(B) Require the health care service plan for a period of three years from the date of the director's determination, or for a shorter period prescribed by the director, to pay complete and accurate claims from the provider within a shorter period of time than that required by Section 1371. The provisions of this subparagraph shall not become operative until January 1, 2002.~~

~~(C) Include a claim for costs incurred by the department in any administrative or judicial action, including investigative expenses and the cost to monitor compliance by the plan.~~

~~(2) For an overpayment made by a health care service plan while subject to the provisions of paragraph (1), the provider shall remain liable to the plan for repayment pursuant to Section 1371.1.~~

~~(e) The enforcement remedies provided in this section are not exclusive and shall not limit or preclude the use of any otherwise available criminal, civil, or administrative remedy.~~

~~(f) The penalties set forth in this section shall not preclude, suspend, affect, or impact any other duty, right, responsibility, or~~

~~obligation under a statute or under a contract between a health care service plan and a provider.~~

~~(g) A health care service plan may not delegate any statutory liability under this section.~~

~~(h) For the purposes of this section, ''complete and accurate claim'' has the same meaning as that provided in the regulations adopted by the department pursuant to subdivision (a) of Section 1371.38.~~

~~(i) On or before December 31, 2001, the department shall report to the Legislature and the Governor information regarding the development of the definition of ''unjust pattern'' as used in this section. This report shall include, but not be limited to, a description of the process used and a list of the parties involved in the department's development of this definition, as well as recommendations for statutory adoption.~~

~~(j) The department shall make available, upon request and on its web site, information regarding actions taken pursuant to this section, including a description of the activities that were the basis for the action.~~

~~SEC. 2.~~

SEC. 3. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

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